Wisconsin Diabetes Strategic Plan 2004 - 2009

Wisconsin Diabetes Advisory Group

October 2004

Wisconsin Diabetes Prevention and Control Program
Division of Public Health
Department of Health and Family Services

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State of Wisconsin
Department of Health and Family Services

Jim Doyle, Governor
Helene Nelson, Secretary

October 2004

Dear Diabetes Partner:

The Wisconsin Diabetes Advisory Group, the Department of Health and Family Services Diabetes Prevention and Control Program, and other partners recently completed the Wisconsin Diabetes Strategic Plan, 2004-2009. The plan's completion demonstrates extraordinary collaboration of statewide partners, including individuals representing health systems, community and non-profit organizations, policymakers, businesses, health care professionals, people with diabetes, academia, and others, to improve the health of people affected by diabetes.

We envision that the plan will:

- Assist all state partners in meeting the *Healthiest Wisconsin 2010* objectives, as the recommendations in this document support the 2010 objectives.
- Focus partner efforts on interventions that are practical, achievable, and realistic in the health environment for persons with diabetes, as well as for those at risk of developing diabetes.
- Increase awareness for those at risk of developing diabetes, especially high-risk populations.
- Encourage design of culturally appropriate interventions to support positive lifestyle changes that prevent or delay the onset of diabetes, and ensure timely and quality care for those diagnosed.

This plan provides a framework for Wisconsin organizations to mobilize around a set of common goals affecting all areas of diabetes care and prevention. The plan was developed with the understanding that most organizations have limited time and resources and that achieving these goals will take a unified effort of many, with each applying different and creative solutions for change. The plan's focus on widespread and far-reaching diabetes prevention and control, along with its emphasis on collaboration, truly make it a statewide "call-to-action."

We encourage everyone to take an active role in implementing the Wisconsin Diabetes Strategic Plan. Please join us in spreading the message that diabetes prevention and control is a priority in Wisconsin.

Sincerely,

Helene Nelson, Secretary
Department of Health and Family Services

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Why Do We Need A Diabetes Plan?

The Wisconsin diabetes community has a strong, positive history of working together on mutual, diabetes-related issues. It is through extensive collaboration that the partners have achieved many broad improvements in diabetes care across the state. In spite of these improvements, much more work remains to be done. Diabetes continues to increase at alarming rates in Wisconsin and across the nation, largely due to overweight, obesity, and physical inactivity. Some children are now developing type 2 diabetes – a disease previously referred to as "adult-onset." Many more people are at increased risk for developing diabetes in the future due to poor eating habits, overweight, obesity, and sedentary lifestyles.

The good news is that we currently have a good understanding of diabetes and how to control it. Even more exciting is the news that we can take actions to improve our lifestyles, leading to the delay or even the prevention of this disease in many people. Simple measures, such as healthier eating and increased physical activity, can greatly reduce the risk of developing diabetes. It is now imperative for us to take advantage of the latest scientific advances and research and expand statewide diabetes activities to work on both diabetes prevention and control. We must work together to maximize our precious human and economic resources if we are going to be successful in reducing the prevalence and impact of this devastating disease on Wisconsin's citizens and future generations.

This Wisconsin Diabetes Strategic Plan (Plan) is intended to serve as a blueprint to help guide collaborative statewide diabetes prevention and control activities over the next five years. It will take the combined efforts and resources of many partners and individuals to achieve a sustained positive impact on diabetes care, prevention, and the creation of healthier communities across the state.

Some highlights outlined in this Plan include:

- A description of diabetes, its risk factors, and strategies for risk reduction.
- Data to show that diabetes is a serious, common, and costly public health epidemic in Wisconsin and across the nation, and to explain why the disease is growing.
- Messages of hope about the controllability of diabetes and strategies for delaying or even preventing this disease.
- A summary showcasing Wisconsin's successful history of collaborative diabetes prevention and control efforts over the past several years.
- A description of the process for development of the Plan.
- Ideas on how to participate in the call to action to help implement the Plan.
- Reporting mechanisms to facilitate coordination and evaluation of the statewide impact of the Plan.

The Plan's common vision, developed by the statewide partners, includes:

- Seven targeted priority areas.
- Specific goals for each of the targeted priority areas.
- Suggested strategies and action steps for collectively achieving the specified goals.

continued

Why Do We Need A Diabetes Plan? (continued)

The goals for the Plan's seven targeted priority areas are to:

- Influence public policy to support and improve diabetes prevention and control.
- Promote prevention, education, and health care services to reduce diabetes-related health disparities.
- Promote early detection and prevention of diabetes in children and adults through collaboration with health systems and communities in Wisconsin.
- Improve and expand diabetes surveillance and monitoring throughout the state to assess the burden of diabetes and guide policy development and evaluation activities.
- Foster and facilitate collaboration among Wisconsin health-related organizations in the development and dissemination of model public diabetes communication programs directed to all population segments, including disparately affected socioeconomic and ethnic groups.
- Collaborate with health systems and providers to ensure care is provided as recommended by the *Wisconsin Essential Diabetes Mellitus Care Guidelines* so that all people with diabetes and those at risk will receive appropriate screening to promote early detection of disease and complications, self-management education, and ongoing management to reduce risk of disease and complications.
- Collaborate with communities to develop, implement, and evaluate policies and interventions that promote healthy lifestyles and improve diabetes management.

Together we can make a difference in the lives of people at risk for, or living with, diabetes.

Introduction

Types of Diabetes

The three main kinds of diabetes are type 1, type 2, and gestational diabetes. Recently, pre-diabetes has been recognized as a separate condition.

Type 1 Diabetes

Type 1 diabetes, formerly called juvenile diabetes or insulin-dependent diabetes, is usually diagnosed in children, teenagers, or young adults. Type 1 diabetes is the most common form of diabetes in children. In this type of diabetes, the beta cells of the pancreas are no longer able to make insulin. Treatment for type 1 diabetes includes taking insulin shots or using an insulin pump. Other healthy lifestyle activities, such as eating healthy meals, getting regular physical activity, and controlling blood pressure and cholesterol, are also very important parts of diabetes care for people with type 1 diabetes.

Type 2 Diabetes

Type 2 diabetes, formerly called adult-onset or noninsulin-dependent diabetes, is the most common form of diabetes in adults; however, it is increasingly being recognized during childhood. This type of diabetes usually begins with insulin resistance, a condition in which fat, muscle, and liver cells do not use insulin properly. The pancreas tries to keep up with the added demand by producing more insulin, eventually losing the ability to secrete enough insulin in response to the amount of food consumed. Overweight, obesity, and inactivity are three risk factors that increase the chances of developing type 2 diabetes. Treatments include oral medications, often in combination with other therapy. Insulin may be required to control blood sugars. Other healthy lifestyle behaviors, such as healthy meal choices, regular physical activity, and controlling blood pressure and cholesterol, are all very helpful and can keep the need for oral medications and/or insulin at a minimum for people with type 2 diabetes.

Gestational Diabetes

Some women develop gestational diabetes during the late stages of pregnancy. This form of diabetes is only associated with pregnancy and subsides after the birth. A woman who has had gestational diabetes is more likely to develop type 2 diabetes later in life. Gestational diabetes is caused by the hormones of pregnancy or a shortage of insulin. Insulin is needed to control blood sugars during pregnancy. Healthy meal choices and physical activity can help keep blood sugars lower; however, insulin may still be required.

Pre-Diabetes

Pre-diabetes is a condition that precedes type 2 diabetes. In pre-diabetes, blood sugar levels are higher than normal but not high enough to be diagnosed as diabetes. Pre-diabetes was formerly called impaired fasting glucose or impaired glucose tolerance.

Risk Factors for Diabetes

There are several factors that increase the risk of developing type 2 diabetes. These factors also increase the risk of developing pre-diabetes.

- ✔ Non-Caucasian ethnicity (Hispanic/Latino, African American, American Indian)
- ✔ Overweight (Body Mass Index [BMI] ≥ 25.0 kg/m^2) or obesity (BMI ≥ 30.0 kg/m^2)
- ✔ Positive family history of diabetes in one or more first degree relatives

continued

Introduction

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- ✔ For women, a previous history of gestational diabetes or delivery of a baby weighing more than 9 pounds at birth
- ✔ History of hypertension (≥140/90 mmHg)
- ✔ History of dyslipidemia (high-density lipoprotien [HDL] <35 mg/dl and/or a triglyceride level >250 mg/dl)
- ✔ Markers of insulin resistance are present (e.g., Acanthosis nigricans and/or waist circumference >40 inches in men and >35 inches in women)
- ✔ History of polycystic ovary syndrome (PCOS)
- ✔ Sedentary lifestyle
- ✔ Documented history of pre-diabetes, formerly known as impaired fasting glucose or impaired glucose tolerance

Screening and Prevention

The American Diabetes Association recently issued new screening guidelines for detecting pre-diabetes in high-risk individuals. Pre-diabetes can lead to type 2 diabetes and increase the risk of developing heart disease by 50 percent. Lifestyle changes, such as moderate physical activity and consuming a healthier diet, can lead to moderate weight loss and may delay or prevent the onset of diabetes.

When addressing the prevention of type 1 diabetes and its cause, pancreatic beta cell failure, it is important to recognize that research has not yet identified interventions that can be widely implemented. For these reasons, when we refer to diabetes prevention in this document, only the prevention of type 2 diabetes is implied.

The Impact of Diabetes in Wisconsin

Diabetes is serious, common, costly, and controllable.

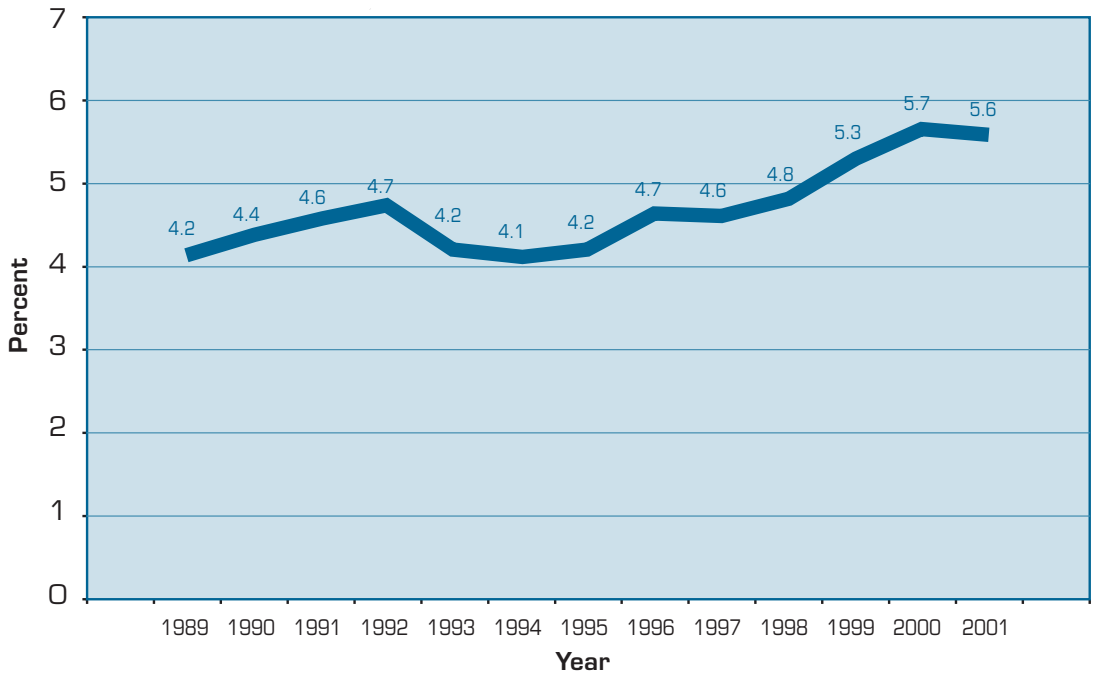
Serious

People with diabetes are at increased risk of numerous complications, including heart disease, blindness, kidney disease, and foot and leg amputations. The majority of people with diabetes eventually die from heart disease. Many adverse outcomes of diabetes complications can be prevented or delayed by an aggressive program of early detection and appropriate treatment.

Common

In Wisconsin, approximately eight percent of adults (329,000) have diabetes – six percent (235,000) with diabetes that has been diagnosed and two percent (94,000) with diabetes that has not been diagnosed.[1] Additionally, an estimated 3,000 children in Wisconsin have been diagnosed with diabetes.[2] The prevalence of diabetes has increased in the past decade (Figure 1). Using a three-year moving average, diabetes has increased 33% from 1989 to 2001 (4.2% to 5.6%). Furthermore, an estimated 836,000 persons in Wisconsin aged 40-74 years have pre-diabetes.[3] Diabetes is more prevalent in certain racial and ethnic populations, including Hispanics/Latinos, African Americans, and American Indians.[4]

Figure 1: Estimated Prevalence of Adults with Diagnosed Diabetes in Wisconsin, Three-Year Moving Average (1988-2002)



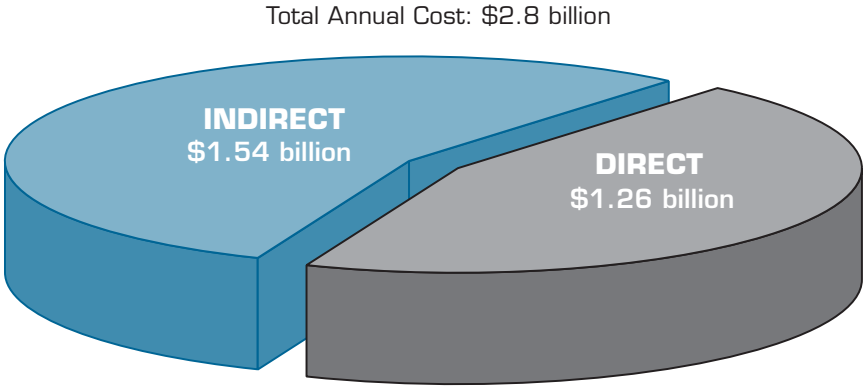
Source: WI Behavioral Risk Factor Survey 1988-2002

The Impact of Diabetes in Wisconsin (continued)

Costly

The cost of diabetes in Wisconsin is staggering (Figure 2). In 1998, estimated direct annual costs (medical care) for diabetes were $1.26 billion and estimated indirect costs (lost workdays, restricted activity days, mortality and permanent disabilities) were $1.54 billion, totaling $2.8 billion.[5]

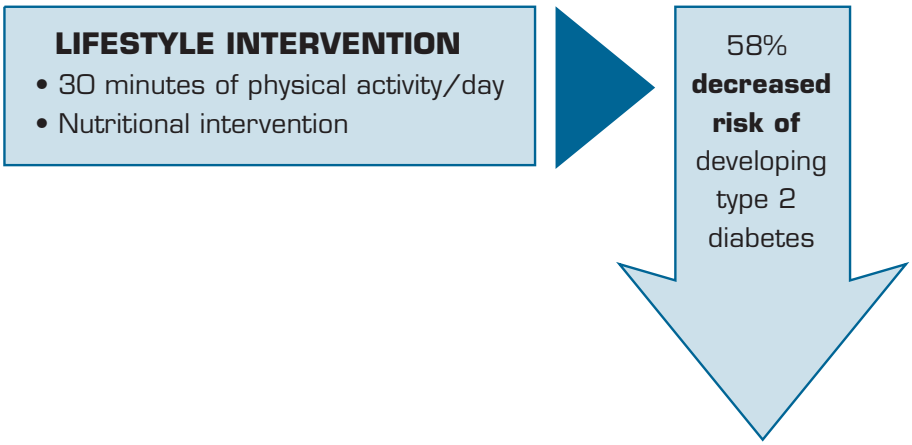
Figure 2: Estimated Direct and Indirect Costs of Diabetes in Wisconsin (1998)



Controllable

The Diabetes Prevention Program Study (August 2001) found that participants randomly assigned to intensive lifestyle intervention (30 minutes of physical activity a day and diet improvement) reduced their risk of developing type 2 diabetes by 58% (Figure 3). These positive results were found for people of all ages and races/ethnic groups.[6] These significant findings offer encouraging evidence that reduction in risk factors with modest lifestyle changes may be the best defense against type 2 diabetes.

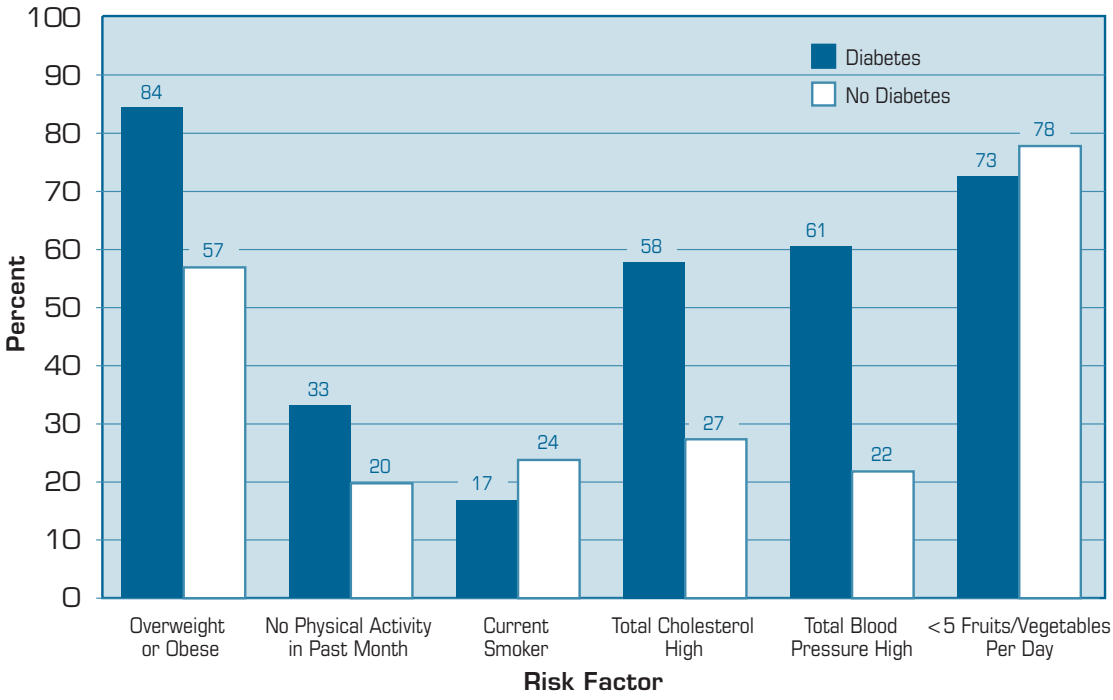
Figure 3: Summary Findings of the Diabetes Prevention Program



Risk Factors

Adults with diabetes tend to have higher prevalence of risk factors for chronic diseases than adults without diabetes (Figure 4).[7] Wisconsin adults with diabetes have a higher prevalence of overweight and obesity, lack of any physical activity, high cholesterol, and high blood pressure than adults in Wisconsin without diabetes. On a positive note, there are fewer Wisconsin adults with diabetes who are current smokers (17%) compared to adults without diabetes (24%). There are also fewer adults with diabetes that do not consume the recommended amount of fruits and vegetables (73%) compared to adults without diabetes (78%).

Figure 4: Comparison of Risk Factor Prevalence Between Adults with and without Diabetes in Wisconsin (2001-2002)



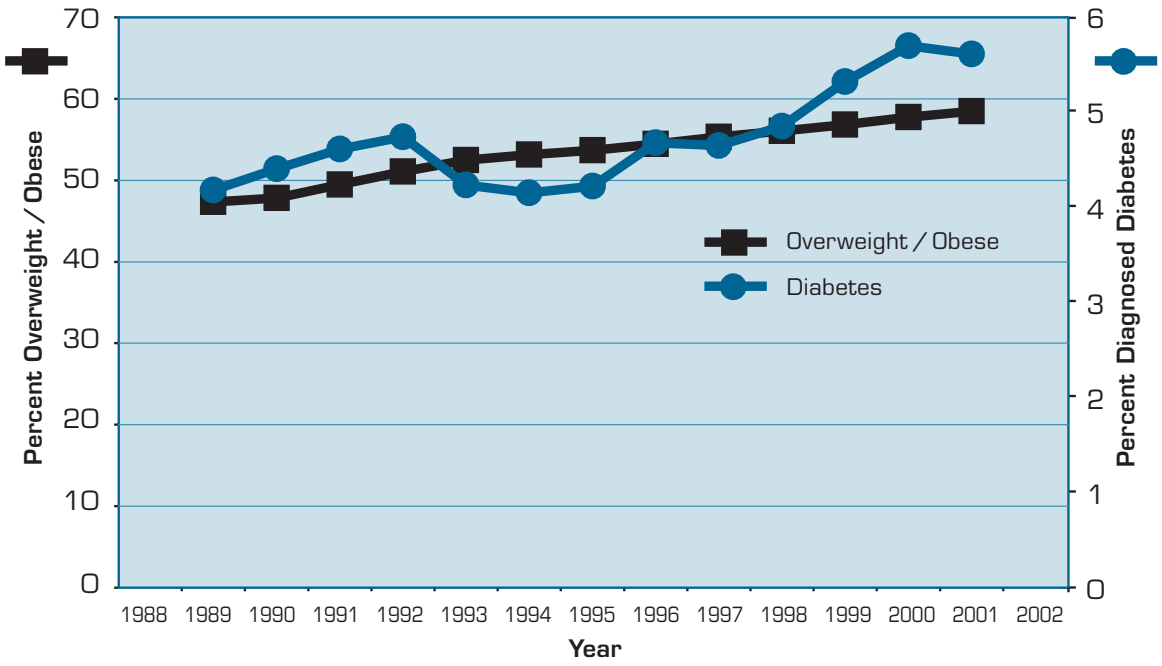
Source: WI Behavioral Risk Factor Survey 2001-2002

The Impact of Diabetes in Wisconsin (continued)

Future Challenges

While diabetes is currently a serious health issue, the prevalence is expected to grow each year as the population diversifies and ages, and as the number of overweight and obese people increase in Wisconsin. Being overweight or obese increases the risk of developing type 2 diabetes; the epidemics of diabetes and overweight/obesity are strongly associated (Figure 5).

Figure 5: Estimated Prevalence of Adults with Diagnosed Diabetes in Wisconsin and Estimated Prevalence of Overweight/Obese Adults in Wisconsin, Three-year Moving Averages (1988-2002)



Overweight/Obese is defined as a body mass index of 25.0 kg/m^2 or above
Source: WI Behavioral Risk Factor Survey 1988-2002

The percentage of persons who are overweight or obese is increasing in Wisconsin and United States adults.[8] Furthermore, the percentage of children and adolescents who are overweight or at risk of overweight has been increasing in the past decade.[9] Health care providers are finding more and more children with onset of type 2 diabetes, a disease usually diagnosed in adults aged 40 years or older.[10] The development of type 2 diabetes in children has enormous implications for associated complications as they move into adulthood.[11]

Disparities in prevalence of diabetes in population groupings will continue to be an ongoing challenge. Diabetes is more prevalent in older populations, as well as certain racial and ethnic populations.

Prevention, Control, and Self-Management of Diabetes

Type 1 diabetes is not a preventable or curable disease. Many research projects are currently underway to find a cause and cure. Type 1 diabetes can be controlled however, by working with a medical team that supports, teaches, and reinforces self-management.

Research studies in the United States and abroad have found that lifestyle changes can reduce risk and possibly delay the onset of type 2 diabetes. People at risk of developing type 2 diabetes can make lifestyle changes to reduce their risk.[12, 13] Such changes include:

- Regular physical activity (e.g., walking) 30 minutes/day for five or more days of the week.
- Aiming for a moderate weight loss of 5-7% of your body weight.
- Maintaining a healthy diet.

People with type 1 and type 2 diabetes are encouraged to develop healthy life-long habits and commit to regular ongoing medical care. They are encouraged to learn self-management as a way to be more actively involved in decisions about their health care and treatment options. Self-management encourages people to accept responsibility for managing their own disease and teaches and encourages problem solving and setting goals. It is well documented that excellent glycemic control can reduce the risk of many complications frequently associated with diabetes. Maintaining near normal blood sugar levels will reduce the risk of potentially debilitating complications associated with diabetes. Adequate screening for complications with early treatment may ultimately lead to an increased quality of life for those living with diabetes.[14]

Wisconsin Plan for Diabetes

History

The Department of Health and Family Services' Diabetes Prevention and Control Program (DPCP) was established through funding from the federal Centers for Disease Control and Prevention (CDC) in 1994. The DPCP is dedicated to improving the health of people at risk for, or with, diabetes by:

- Working with health systems.
- Designing population-based community interventions and health communications.
- Outreaching to address diabetes-related health disparities in high-risk populations.
- Conducting surveillance and evaluation of the burden of diabetes.
- Coordinating statewide efforts.

To build the infrastructure to improve diabetes care and coordinate statewide efforts, the DPCP established the Diabetes Advisory Group (DAG) in 1997. Forming and maintaining strong, active partnerships are essential to achieving statewide improvements. The DAG, comprised of key diverse, dynamic stakeholders in diabetes care, provides guidance and expertise to the DPCP and this, in turn, serves as the foundation for the Wisconsin Diabetes Strategic Plan. DAG members represent organizations working to improve diabetes care and outcomes and address diabetes-related health disparities in high-risk populations. DAG members represent health care systems, health care professional organizations, managed care organizations, other insurers, business coalitions, voluntary and community-based organizations, academic centers, consumers, and public health. Over the past seven years, these dedicated partners have contributed their talents to many successful statewide initiatives, assisting the DPCP with the following accomplishments:

- Developed and revised the *Wisconsin Essential Diabetes Mellitus Care Guidelines*, evidence-based recommendations that have been widely adopted and implemented by health systems and providers statewide
- Health communications campaigns to raise awareness about diabetes, including targeted messages to populations disparately affected by diabetes
- Statewide quality improvement initiatives among competitive health systems
- Joint quality improvement and capacity building efforts with community health centers that serve populations disparately affected by diabetes
- Professional and public education activities
- Community interventions aimed at high-risk populations
- Expansion of diabetes-related data sources and development of the Burden of Diabetes and other publications
- Improvements in diabetes-related state legislation
- Evaluation of the diabetes health system in Wisconsin
- Sharing and presentation of activities and initiatives through journal articles and national conference presentations

The DPCP, with the DAG's assistance, has been instrumental in achieving many statewide improvements; however, work to prevent and control diabetes in Wisconsin must continue and expand in order to meet the current and future needs. Continuing collaboration with current and new partners is essential to sustain and expand the improvements in diabetes care statewide. The Wisconsin Diabetes Strategic Plan addresses ongoing challenges in primary prevention and treatment, including the need for expanded activities aimed at screening and early detection, health promotion, increased physical activity, risk factor reduction, disease management, provider and public education, access to high quality care, and the elimination of diabetes-related health disparities.

Wisconsin Plan for Diabetes

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The DPCP and the DAG are committed to improving Wisconsin's diabetes health system based on the national objectives and state priorities.

The national objectives, determined by the Centers for Disease Control and Prevention, Division of Diabetes Translation are:

- Establish measurement procedures to track program success in improving diabetes care
- Increase the percentage of people with diabetes who receive:
  - ➢ Recommended foot exams (routine and comprehensive)
  - ➢ Recommended annual diabetic eye exams
  - ➢ Recommended annual influenza vaccination
  - ➢ Recommended pneumococcal vaccination
  - ➢ Recommended "A1c" tests (long-term blood sugar tests)
- Reduce diabetes-related health disparities for high-risk populations
- Establish programs for wellness, physical activity, weight and blood pressure control, and smoking cessation for people with diabetes

Relevant health priorities in the Wisconsin state health plan, *Healthiest Wisconsin 2010 – A Partnership Plan to Improve the Health of the Public*[15], include:

- Access to primary and preventive health services
- Adequate and appropriate nutrition
- Mental health and mental disorders
- Overweight, obesity, and lack of physical activity
- Social and economic factors that influence health
- Tobacco use and exposure

The Strategic Planning Process

The strategic planning process involves the four steps listed below:

(1) Assessment: From where are we starting?

In the spring of 2003, the Department of Health and Family Services' Diabetes Prevention and Control Program (DPCP) began a process to assess the current level of function of the State Diabetes Health System (SDHS). The purpose of this analysis was to assess the statewide infrastructure that promotes diabetes prevention and provides diabetes care in Wisconsin by all diabetes partners in Wisconsin. The tool for conducting this assessment was based on the Essential Public Health Services (EPHS), which were developed in 1994 by the national Public Health Functions Steering Committee and adapted by the Wisconsin Turning Point Transformation Team. DAG members and the DPCP identified participants from across the state and invited them to complete the assessment. The identified gaps and results of the EPHS Assessment will guide future statewide improvement efforts, including the Diabetes Strategic Plan, and will serve as a benchmark for future evaluation.

(2) Ends Planning: What is the future we want to create?

The DAG set aside a day in July 2003 to collaborate with the DPCP on their efforts to review past diabetes prevention and control in Wisconsin and map out new objectives (2004-2009) for a state plan. Work groups developed preliminary goals, strategies, action steps, and measures for seven areas in the Plan.
The seven areas are the following:

- Advocacy and Public Policy
- Disparately Affected Populations
- Early Detection and Prevention
- Epidemiology and Surveillance
- Health Communications and Public Awareness
- Health Systems and Providers
- Population-Based Community Intervention

(3) Means Planning: How do we get there from here?

Based on the initial work completed in July 2003, DPCP staff and work group members further refined the goals, strategies, action steps, and measures for the Diabetes Strategic Plan and created a draft document to review with the full DAG membership. After full DAG approval, this document was shared with member organizations for reaction. Organizations endorsed the plan and committed their resources to take a role in reducing the burden of diabetes in Wisconsin. Members identified gaps in implementation (i.e., parts of the plan that would likely not be accomplished through organizational or member support). These will require more intensive DPCP efforts or special funding for implementation. Where these merge with the EPHS gaps, additional funding will be sought.

(4) Implementation, Evaluation, and Adjustment

There are four vehicles or agents for implementation:

- Diabetes Prevention and Control Program Staff – DPCP staff are leaders in state plan activities
- Work Group Members – Ad hoc work group projects allow DPCP staff and DAG members to collaborate on action items
- Partner Organizations – Many organizations can incorporate goals, strategies, or action steps into their work, and in effect, support statewide strategic direction
- Grants or Funding for Special Projects – Special work groups may be convened with project funding from the CDC or other sources

Data Collection and Measurement

Several and varied data sources will be employed to measure and evaluate the progress of the Wisconsin Diabetes Strategic Plan. Some of these are the following:

- Wisconsin Behavioral Risk Factor Survey (BRFS)
- Wisconsin Youth Risk Behavior Survey (YRBS)
- Wisconsin Inpatient Hospitalization Discharge Database
- Wisconsin Emergency Department Visits
- Wisconsin Mortality Files
- End-stage Renal Disease (ESRD) Network Data
- Wisconsin Medicaid Program Data
- Wisconsin Medicare Program Data
- Wisconsin Census Records and Population Estimates
- Wisconsin Birth Records
- Wisconsin Family Health Survey
- Wisconsin Collaborative Diabetes Quality Improvement Project Data
- Wisconsin Diabetes Quality Improvement Project Data from the Section-330 Federally-Qualified Community Health Centers

Ongoing evaluation of diabetes-related data, using the above data sources, will allow for periodic monitoring of progress toward objectives of the Wisconsin Diabetes Strategic Plan. These data provide knowledge of the successes and allow for informed future modifications or enhancements to the Plan.

Strategic Plan Sections

- Advocacy and Public Policy
- Disparately Affected Populations
- Early Detection and Prevention
- Epidemiology and Surveillance
- Health Communications and Public Awareness
- Health Systems and Providers
- Population-Based Community Interventions

Advocacy and Public Policy

GOAL: Influence public policy to support and improve diabetes prevention and control

STRATEGY 1: Build and mobilize a statewide diabetes advocacy infrastructure and network to coordinate and conduct advocacy activities

Action Steps:

- Identify and cultivate state and local champion partners.
- Establish a network to inform people in Wisconsin and state policy makers about issues related to high quality diabetes care and prevention.
- Identify or develop fact sheets highlighting the human and economic costs of diabetes in Wisconsin, including the costs and benefits of good diabetes management.
- Coordinate with other diabetes-related public policy initiatives statewide.
- Identify, develop, and promote effective strategies for policy change and advocacy that benefit prevention and good diabetes care.
- Engage health professionals and organizations in advocating for diabetes care issues.

STRATEGY 2: Educate and motivate policy makers, community leaders, and funding sources to promote public policies and programs that support diabetes prevention and control

Action Steps:

- Collaborate at the state and local levels to identify high-priority community diabetes-related health issues.
- Engage local communities to identify effective strategies and advocate for targeted solutions.
- Support advocacy training in local communities.
- Use the Wisconsin Diabetes Strategic Plan as a communication and guidance tool with key local community leaders.
- Advocate for funding of state and local diabetes treatment and prevention activities and programs working/occurring at the community level.

Advocacy and Public Policy

STRATEGY 3: Work with schools to improve environmental and education policies for healthy nutrition and physical activity

Action Steps:

- Develop collaborative recommendations to guide student health curricula.
- Engage youth, youth programs, and youth advisory groups in advocating for school and community environmental and policy change.
- Participate in policy changes and efforts to improve healthy nutrition and physical activity programs in schools and communities.

STRATEGY 4: Improve reimbursement for diabetes self-management training and medical nutrition therapy services

Action Steps:

- Identify existing evidence supporting the effectiveness of diabetes self-management training and medical nutrition therapy services and communicate to statewide partners.
- Collaborate with elected officials to develop strategies for improving federal and state reimbursement for diabetes self-management training, medical nutrition therapy, and counseling services to help manage and prevent diabetes.
- Encourage health insurance purchasers and insurers to offer full coverage for all services and supplies needed for comprehensive diabetes care, including self-management training and medical nutrition therapy.
- Educate consumers on reimbursement issues and advocacy to improve reimbursement for diabetes self-management training and medical nutrition therapy services.

Disparately Affected Populations

GOAL: Promote prevention, education, and health care services to reduce diabetes-related health disparities

STRATEGY 1: Enhance cultural competence of health care professionals

Action Steps:

- Develop ongoing cultural competency training resources that utilize national standards.
- Provide educational and training experiences for health care professionals to improve the cultural appropriateness of diabetes care for the populations served.
- Evaluate curricula in health profession schools to assure that diabetes educational materials are culturally appropriate.
- Develop partnerships with medical, pharmacy and nursing schools, Area Health Education Centers (AHECs), state and local medical and pharmacy societies, and other health professionals and organizations representing diverse populations to assure culturally appropriate curriculum development.
- Promote integration of lessons learned about providing culturally competent diabetes prevention and control education and counseling in the practice.
- Emphasize the importance of client health literacy[16] in the training of health professionals and the management of diabetes.
- Encourage diverse participation in DAG and statewide activities.

STRATEGY 2: Identify and implement culturally appropriate and effective prevention strategies to identify and reduce diabetes-related health disparities

Action Steps:

- Work with organizations involved in nutrition and physical activity to promote simple, consistent messages that providers can use with high-risk patients and families.
- In collaboration with partners involved in the Health Communication and Public Awareness workgroup, expand on the availability of diabetes resources offered to providers and consumers in multiple versions, serving varying literacy levels and languages.
- Collaborate with Federally Qualified Health Care Centers (FQHCs), health care plans, provider groups, and others serving disparately affected populations to deliver messages and tools to promote appropriate diabetes screening and management and enhance culturally appropriate care.
- Promote health care access to appropriate diabetes care for the uninsured and underinsured population.

- Identify health care providers who are champions of diabetes prevention in local communities, encourage them to serve as messengers, and provide easy-to-use educational tools (i.e., talking points for provider-patient discussions about overweight, sedentary lifestyle, and nutrition).
- Collect and analyze encounter and health care data within health care systems to identify gaps and resolve racial and ethnic inequities in diabetes screening and management.

STRATEGY 3: Build community support and leadership to promote diabetes prevention and enhance diabetes self-care management skills

Action Steps:

- Educate community groups, community health workers, schools, people with diabetes, and families in high-risk populations to understand their role in diabetes prevention and care.
- Work to raise awareness of diabetes and diabetes prevention among community leaders who represent various ethnic and cultural groups.
- Partner with groups that have identified community leaders in order to prioritize community-driven and culturally appropriate initiatives.
- Implement a diabetes awareness and education needs assessment among targeted groups.

STRATEGY 4: Empower people in disparately affected populations with diabetes to participate actively in their care

Action Steps:

- Encourage patients to use the available Wisconsin self-management tools.
- Distribute culturally specific educational materials.
- Utilize non-traditional sites such as schools, work sites, and faith-based organizations to promote self-management.

STRATEGY 5: Promote grant writing training to gain access to funding that supports community-focused activities in disparately affected populations

Action Steps:

- Partner with local agencies to provide training to community partners.
- Seek opportunities and provide support to participate in grant writing workshops/seminars.

Early Detection and Prevention

GOAL: Promote early detection and prevention of diabetes in children and adults through collaboration with health systems and communities in Wisconsin

STRATEGY 1: Identify children and adults with pre-diabetes and diabetes through use of evidence-based guidelines

Action Steps:

- Develop a training and implementation plan to identify children and adults with pre-diabetes or diabetes.
- Coordinate with partners involved in the Health Systems and Providers workgroup to develop consensus on screening options and community outreach recommendations for early detection of diabetes and pre-diabetes.
- Disseminate the recommendations, provide training, and implement the plan.
- Evaluate implementation and share lessons learned with partners throughout the State Diabetes Health System.

STRATEGY 2: Implement effective interventions that support healthy lifestyles and early detection of diabetes

Action Steps:

- Identify effective early detection and prevention models and resources.
- Create a diabetes early detection and prevention resource tool kit that is appropriate for use with individuals from various cultural backgrounds.
- Develop broad-based community collaboratives to support, promote, and disseminate the diabetes early detection and prevention resource tool kit to local partners, such as local health departments, non-profit organizations, schools, employers, work sites, grocers, restaurants, community centers, youth groups, etc.
- Support implementation of interventions and work with existing groups that are implementing environmental and policy changes supporting healthy lifestyles.
- Evaluate interventions and share lessons learned.

STRATEGY 3: Promote professional education opportunities on risk factor assessment, behavior change counseling skills, diabetes prevention and control, and cultural competency

Action Steps:

- Collaborate with partners to assess education needs, resources, trainers, and level of cultural competency of professional health care staff.
- Research available technology to maximize outreach and ensure inclusion of practitioners who work with diverse populations.
- Share new scientific findings that translate research into practice.

Epidemiology and Surveillance

GOAL: Improve and expand diabetes surveillance and monitoring throughout the state to assess the burden of diabetes and guide policy development and evaluation activities

STRATEGY 1: Enhance the capacity of statewide surveillance to improve the collection, quality, and scope of population-based diabetes-related data

Action Steps:

- Develop consensus on a set of uniform indicators by which to assess the burden of diabetes in Wisconsin.
- Collaborate to investigate and improve accuracy of coding classification of type 1 and type 2 diabetes.
- Use and/or encourage broader use of electronic medical records or similar methods that support new and innovative ways to collect, monitor, and analyze diabetes-related data.
- Collaborate to use and encourage utilization of organization-level diabetes registries to identify quality of care issues and promote continuous quality improvement of diabetes care.
- Continue to quantify diabetes prevalence, complications, and care among disparately affected populations.
- Assess feasibility of a future statewide diabetes registry.
- Increase access to diabetes-related data and promote effective communication of diabetes issues to policy makers, partners, health professionals, and the public for informed program planning and policy development.

STRATEGY 2: Expand surveillance to enhance collection of information on children with, and at risk for, diabetes

Action Steps:

- Develop consensus on a uniform indicator set to assess the burden of diabetes in Wisconsin's children.
- Collaborate to investigate and improve accuracy of coding classification of type 1 and type 2 diabetes in children.
- Advocate for and support consistent and complete data collection on children with, and at risk for, diabetes, including overweight and at risk for overweight.
- Collaborate to use and encourage utilization of organization-level diabetes registries for children to identify quality of care issues and promote continuous quality improvement of diabetes care in children.
- Effectively communicate diabetes-related data issues specific to children and their health to policy makers, partners, health professionals, and the public.

Epidemiology and Surveillance

STRATEGY 3: Develop surveillance capacity to monitor pre-diabetes

Action Steps:

- Develop consensus on a uniform indicator set by which to assess the burden of pre-diabetes in Wisconsin.
- Develop and implement methods to monitor, assess, and report on populations most at risk for developing pre-diabetes.
- Use and encourage broader use of electronic medical records or similar methods that support new and innovative ways to collect, monitor, and analyze pre-diabetes data.

Health Communication and Public Awareness

GOAL: Foster and facilitate collaboration among Wisconsin health-related organizations in the development and dissemination of model public diabetes communication programs directed to all population segments, including disparately affected socioeconomic and ethnic groups

STRATEGY 1: Create, maintain, and share a continuously updated repository of diabetes public communication messages about awareness, prevention, and control, as well as objective data and case histories demonstrating their execution effectiveness

Action Steps:

- Convene a symposium of communications managers representing Wisconsin and national health-related organizations that conduct public communications, including industry, to discuss past and present diabetes-related communication objectives, messages, and research demonstrating effectiveness.
- Assess the need for further message research with special population groups or segments.
- Develop and implement a plan to acquire funding for additional and continuing diabetes-related message research as indicated by findings.

STRATEGY 2: Create, maintain, and share a continuously updated repository of diabetes public communication messengers of all types (print, broadcast, electronic, third party delivery, paid and non-paid) along with objective data and case histories concerning their efficiency and efficacy

Action Steps:

- At the same time, or subsequent to the symposium for messages, discuss past and present communication objectives, messengers (message distribution channels) and research related to their effectiveness.
- Integrate message experiences into a synopsis of best communication practices with special and segmented general population groups; categorize research methods and costs experience.

STRATEGY 3: Facilitate the development of meaningful measures to evaluate communication impact

Action Steps:

- Identify benchmarks for measuring communications efficacy over time, e.g., awareness, knowledge, attitude, actions.
- Identify priorities and methods for further objective cost-effectiveness research and analysis.
- Encourage Wisconsin health-related organizations to develop further communications message and messenger research, as well as case histories to be added to a continuously growing information base of cost-effective health communication research.

Health Communication and Public Awareness

STRATEGY 4: Inform and involve Wisconsin health providers in public diabetes communication programs and communications research findings

Action Steps:

- In collaboration with partners involved with Health Systems and Provider workgroup interventions, periodically make Wisconsin health care professionals aware of public communication efforts, including findings that may influence their patient communications.
- Establish revolving panels of primary physician and diabetes educator offices to administer diabetes-related waiting room patient questionnaires and deliver them to a central source for data entry, periodic analysis, and reporting.
- Work with partner organizations to promote simple, consistent messages that providers can use with high-risk patients.
- Find community partner champions to serve as messengers and support them through provision of easy-to-use tools.
- Seek external funding as needed to measure changes in public perception and actions due to communications.

Health Systems and Providers

GOAL: Improve and expand collaboration with health systems and providers to ensure care is provided as recommended by the *Wisconsin Essential Diabetes Mellitus Care Guidelines* so that all people with diabetes and those at risk will receive appropriate screening to promote early detection of disease and complications, self-management education, and ongoing management to reduce risk of disease and complications

STRATEGY 1: Improve the delivery of comprehensive diabetes care by implementing the current *Wisconsin Essential Diabetes Mellitus Care Guidelines,* Diabetes Prevention and Control Program resources, and other culturally appropriate and evidenced-based tools to health systems, payers, health professionals, and community partners

Action Steps:

- Collaborate with the Diabetes Advisory Group.
- Obtain, endorse, and implement the *Wisconsin Essential Diabetes Mellitus Care Guidelines*, Diabetes Prevention and Control Program resources, and other relevant and culturally appropriate resources.
- Measure success and identify areas for improvement by evaluating the implementation of *Guidelines* and other initiatives.
- Share lessons learned and build on successes.
- Maintain and expand partnerships for sharing new research, resources, and strategies with professionals, providers, health and community organizations, and other collaborators.

STRATEGY 2: Enhance partnerships and increase communication with payers, providers, health and community organizations, and other relevant partners to promote and support prevention education, early screening for diabetes, early detection of complications, self-management support, and ongoing interdisciplinary disease management

Action Steps:

- Identify and seek new partnerships to enhance and strengthen diabetes control and prevention programs.
- Collaborate with partners involved in the Early Detection and Prevention workgroup to design, test, implement, and evaluate effective prevention and control models, and best practice interventions.
- Coordinate with partners and provide supportive educational programs for prevention and control of diabetes, healthy lifestyles and disease management.
- Identify relevant communication channels to inform partners of current and future initiatives, along with progress reports and final analysis of outcome data.
- Engage community stakeholders in implementation of programs and provision of educational opportunities.
- Monitor and review collaborative activities and maintain partnership momentum.

STRATEGY 3: Increase and support health professional education opportunities in lifestyle modification, behavior change, and disease management, including skills for providing aggressive risk reduction counseling and client empowerment

Action Steps:

- Collaborate with partners to conduct needs assessments for professional education regarding aggressive risk reduction education and disease management skills.
- Research and design programs for dissemination to professionals, including information and tools in motivating clients in making lifestyle modifications.
- Establish effective and convenient communication channels to inform and encourage program participation.
- Investigate provider incentives for assuring the provision of comprehensive diabetes care and effective risk reduction practices. Encourage organizations to offer professional tuition reimbursement, paid educational days, and Continuing Education Units.
- Solicit organizational and provider models to share best practices and benefits of adopting successful strategies.
- Enhance the "team" concept to share supportive expertise from other professionals.
- Investigate, test, and adopt data systems and other resources that aid in disease management and tracking outcomes.
- Identify, collect, and evaluate relevant outcome measures to assess and direct future initiatives.

Population-Based Community Interventions

GOAL: Collaborate with communities to develop, implement, and evaluate policies and interventions to promote healthy lifestyles and improve diabetes management

STRATEGY 1: Collaborate with community partners, especially those who serve disparately-affected populations, to assess local needs and implement interventions (e.g., environmental change policies and public education efforts) that are culturally appropriate and support healthy lifestyles and diabetes self-management skills

Action Steps:

- Collaborate with established community health coalitions to support local needs assessments and implement innovative and culturally appropriate prevention models and environmental change policies that promote the control and prevention of diabetes.
- Collaborate to ensure that local interventions are user-friendly, accessible, and promote a welcoming, action-oriented emphasis.
- Collaborate with businesses and employers to implement work site health programs and benefits that promote physical activity, healthy eating, and smoking cessation, and enhance self-management skills.
- Assure that special needs of community members with diabetes, especially seniors, disabled, and disparately affected populations, are met by removing barriers to health care access and participation in health and fitness-related community programs.
- Identify and support community champions for promotion of local primary prevention messages and activities.

STRATEGY 2: Collaborate with communities, schools, PTAs, food service, and childcare providers to implement and evaluate policies and interventions to help prevent diabetes and ensure safe care for children with diabetes

Action Steps:

- Provide technical assistance to help schools plan and implement policy changes and activities to improve healthy nutrition, physical activity, and health education programs.
- Encourage engagement of youth, youth programs, and youth advisory groups in planning and implementing school and community initiatives to improve physical activity and nutrition.
- Collaborate with schools and related partners to distribute and implement the tool, *Children with Diabetes–A Resource Guide for Wisconsin Schools and Families*.
- Collaborate with communities, schools, and childcare providers to facilitate educational opportunities, resources, and awareness campaigns on diabetes prevention and safe diabetes management for children.
- Develop and distribute talking points and tools to help schools and communities address healthy lifestyle modification, weight management, healthy eating, and physical activity for children.

Population-Based Community Interventions

STRATEGY 3: Identify, develop, implement, and evaluate behavioral strategies that encourage personal accountability as a means to achieve healthier lifestyles to help prevent and control diabetes

Action Steps:

- Research, develop, and distribute to community partners a toolbox of promising behavior change strategies, culturally appropriate interventions, and evaluation protocols that promote healthy lifestyles and personal responsibility, and can be adapted to meet local needs.
- Collaborate with partners to provide technical assistance and support for training, planning, implementation, and evaluation of the toolbox strategies, interventions, and evaluation protocols.
- Publish findings and share lessons learned.

STRATEGY 4: Assure community access to reliable, accurate, and culturally relevant patient education resources and information

Action Steps:

- Publish and distribute a listing of internet sites for accurate, culturally specific, and downloadable patient education resources and computer-based education programs.
- Update the Wisconsin Diabetes Prevention and Control Program web site and the Diabetes Resource Guide to include the recommended internet sites.
- Provide resource training for professional and community members who work in diabetes research, diabetes education, supportive social services, libraries, and public-use internet facilities.
- Distribute the internet listing and other relevant information to local print media and community cable television stations to engage them in promotion of diabetes awareness, education, and advocacy efforts in publications and local programming.

Call to Action, How to Get Involved

The Wisconsin Diabetes Strategic Plan is a call to action, urging everyone to take a role in reducing the burden of diabetes in Wisconsin.

How to Get Involved

This is a Plan for the State of Wisconsin. To achieve these goals, many partners will need to apply different and creative solutions to change system, community, and individual behaviors. It will take active involvement by public and private partners to ensure that priority areas in diabetes are addressed. Statewide groups will need to work to affect state and national level policy changes that support initiatives developed in this plan and individual residents of Wisconsin will need to take action to change their own environments and behavior. Diabetes is a serious, common, costly, and growing problem that cannot be solved by a single organization, group, or individual. By working together, we can develop action steps that may prevent or delay the onset of diabetes in Wisconsin residents and improve care for those individuals already living with diabetes.

What You Can Do

1. Review the Plan, Goals, and Recommendations. Identify specific items with which your organization may be involved or plan to address.
2. Make a commitment. Become a partner with the Wisconsin Diabetes Prevention and Control Program and others in preventing and controlling diabetes.
3. Register your endorsement of the Plan. Registration is open to anyone with existing activities, new ideas, or simply an interest in being involved.
4. Team with other Plan registrants or groups in your community who share your goals. Foster viable collaborations and partnerships at all levels.

What Does It Mean to Endorse the Wisconsin Diabetes Strategic Plan

After you endorse the plan, your name/organization will be acknowledged on the Plan web site and in Plan-related promotional materials, but your contact information will remain confidential and not used for any other purpose. As partners register, the DPCP will track the activities taking place in Wisconsin and identify the areas where additional work is required. The DPCP will also assist with evaluation of the Plan and, based on the results of the evaluation, make suggestions for future actions.

How to Endorse the Wisconsin Diabetes Strategic Plan

You may endorse the Wisconsin Diabetes Strategic Plan in one of the following ways:

1. Print out and complete the form on the following page. Fax the form to Judy Wing at (608) 266-8925.
2. View the following website: http://dhfs.wisconsin.gov/health/diabetes/stratplan.htm. You may fill out and submit your endorsement online OR open the Word file, fill out the form, and send the saved form to Judy Wing at wingja@dhfs.state.wi.us.

We believe that your action in addressing diabetes will make a notable difference in the lives of those with, or at risk for, diabetes in Wisconsin!

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Public Health
DPH 43020 (06/04)

STATE OF WISCONSIN
Bureau of Community Health Promotion
(608) 261-6855

WISCONSIN DIABETES STRATEGIC PLAN ENDORSEMENT

Instructions: Use the tab key to move through the form. Save the completed form to a hard drive. Email the saved form to wingja@dhfs.state.wi.us , or print a copy and fax to Wisconsin Diabetes Prevention and Control Program at (608) 266-8925.

Note: Your endorsement may be publicly acknowledged on the Diabetes Prevention and Control Program web site and in plan-related materials.

1. I am endorsing the Wisconsin Diabetes Strategic Plan as an:

   ☐ Individual (Go to number 6) ☐ Organization

2. Give your full name, or the name of organization or group:

   _____

3. List the standard abbreviation or acronym, if any, used by the organization or group:

   _____

4. What type of organization do you represent? (Choose up to three)

   ☐ Coalition
   ☐ Community Group
   ☐ Food Service/Restaurant
   ☐ Health Plan/Insurer
   ☐ Professional Association
   ☐ Recreational/Sports Setting
   ☐ Retail/Business Setting
   ☐ Work site/Employer
   ☐ Communication/Media
   ☐ Faith Community
   ☐ Health Care Delivery
   ☐ Government Agency Non-Profit
   ☐ Public Health Department
   ☐ Research Institution
   ☐ School/College/University
   ☐ Other

5. I can provide a link from my organization's web site to the Wisconsin Diabetes Strategic Plan (located at http://dhfs.wisconsin.gov/health/diabetes/stratplan.htm).

   ☐ Yes, and I will ☐ No

6. What Wisconsin Diabetes Strategic Plan activities can you and/or your organization work on to help us accomplish the goals?

Contact Information (The following information will be kept confidential)

Contact Name: _____ Credentials: _____

Organization (if applicable): _____

Position/Title: _____

Mailing Address: _____

Telephone No. ( ) _____ Fax No. ( ) _____

E-mail: _____

Website: _____

Strategic Plan Logic Model

PLAN COMPONENT	ACTIONS	STRATEGIES	GOALS
Advocacy and Public Policy	• Expand and cultivate networks of state and local champions to advocate for diabetes prevention and control issues. • Identify and/or develop and disseminate advocacy materials that include diabetes facts, costs, and the economic benefits of good management.	Coordinated, effective diabetes advocacy networks operate in all regions and populations of Wisconsin.	Public policies and programs that support diabetes prevention and control.
	• Collaborate at the state and local levels to identify high-priority community diabetes-related health issues and effective solutions. • Advocate for funding of state and local diabetes treatment and prevention programs.	Diabetes care and financing issues are discussed and effectively addressed at the state and local levels.	
	• Develop collaborative recommendations to guide student health curricula. • Engage youth, youth programs, and youth advisory groups in advocating for school and community, environmental, and policy change.	Schools and communities have improved environmental and education policies supporting healthy nutrition and physical activity.	
	• Collaborate with elected officials to improve federal and state reimbursement of diabetes self-management training, medical nutrition therapy, and counseling services. • Advocate with health insurance purchasers and insurers for full coverage of all services and supplies needed for comprehensive diabetes care. • Empower consumers to advocate for reimbursement of comprehensive diabetes care.	Reimbursement is improved for comprehensive diabetes care including self-management training, medical nutrition therapy, and counseling services.	
Disparately Affected Populations	• In collaboration with health professions schools and using national standards, provide education and training experiences for health care professionals to improve the cultural appropriateness of diabetes care for the populations being served. • Promote the integration of lessons learned about culturally competent diabetes prevention and control education and counseling into health care practice. • When training health professionals, emphasize the importance of client health literacy on the management of diabetes.	Cultural competence of health care professionals is enhanced.	Diabetes-related health disparities are reduced.
	• Expand on the availability of diabetes prevention and care resources offered to providers and consumers with simple, consistent messages in multiple versions meant for varying literacy levels and languages. • Expand and cultivate outlets for delivering messages and tools that promote appropriate diabetes screening and management and enhance culturally appropriate care. • Promote access to appropriate diabetes care for the uninsured and underinsured population. • Collect and analyze encounter and health care data within health care systems to identify gaps and resolve racial and ethnic inequalities in diabetes screening and management.	Culturally appropriate and effective prevention strategies to identify and reduce diabetes-related health disparities are implemented.	
	• Implement a diabetes awareness and education needs assessment among targeted groups. • Empower community groups, community health workers, schools, people with diabetes, and families in high risk populations to raise awareness of diabetes and diabetes prevention.	Communities promote locally appropriate diabetes prevention and self-management initiatives.	
	• Seek opportunities and provide support for members of disparately affected populations to improve their grant writing skills. • Increase distribution of notices for funding opportunities in disparately affected populations.	Funding that supports community-focused activities is increased in disparately affected populations.	

Strategic Plan Logic Model

PLAN COMPONENT	ACTIONS	STRATEGIES	GOALS
Early Detection and Prevention	• Develop and carry out training, implementation, and evaluation plans to diagnose or identify children and adults with pre-diabetes or diabetes.	Children and adults with pre-diabetes and diabetes are diagnosed through the use of evidence-based guidelines.	Pre-diabetes and diabetes in children and adults in Wisconsin are prevented or promptly diagnosed.
	• Develop broad-based community collaboratives between local partners to support, promote and disseminate a diabetes early detection and prevention resource tool kit appropriate for use with individuals from various cultural backgrounds. • Support implementation of interventions and work with existing groups to implement environmental and policy changes that support and encourage healthy lifestyles.	Effective interventions that support healthy lifestyles and early detection of diabetes are implemented in communities statewide.	
	• Use available technologies for professional education to maximize outreach and ensure inclusion of practitioners who work with diverse populations in trainings, including risk factor assessment, behavior change counseling, diabetes prevention, control, and cultural competency.	Professional education opportunities that share new scientific findings translating research into practice are available to all providers in Wisconsin.	
Epidemiology and Surveillance	• Develop consensus on a set of uniform indicators by which to assess the burden of diabetes in Wisconsin adults and children. • Collaborate to investigate and improve accuracy of coding classification of type 1 and type 2 diabetes. • Use and encourage broader use of electronic medical records or similar methods that support new and innovative ways to collect, monitor, and analyze diabetes-related data. • Collaborate to use and encourage utilization of organization-level diabetes registries to identify quality of care issues and promote continuous quality improvement of diabetes care. • Advocate for and support consistent and complete collection of data on children with, and at risk for, diabetes. • Continue to quantify diabetes prevalence, complications, and care among disparately affected populations. • Assess feasibility of a future state-wide diabetes registry. • For informed program planning and policy development, increase access to diabetes-related data and promote effective communication of diabetes issues to policy makers, partners, health professionals, and the public.	Collection, quality, and scope of population-based surveillance data is expanded for adults, children, and disparately affected populations with, and at risk for, diabetes.	Diabetes-related programs and policies are developed and evaluated based on comprehensive and accurate epidemiologic surveillance information.
	• Develop consensus on a set of uniform indicators by which to assess the burden of pre-diabetes in Wisconsin. • Develop and implement methods to monitor, assess, and report on populations most at risk for developing pre-diabetes. • Use and encourage broader use of electronic medical records or similar methods that support new and innovative ways to collect, monitor, and analyze pre-diabetes data.	Surveillance capacity to monitor pre-diabetes is developed.	

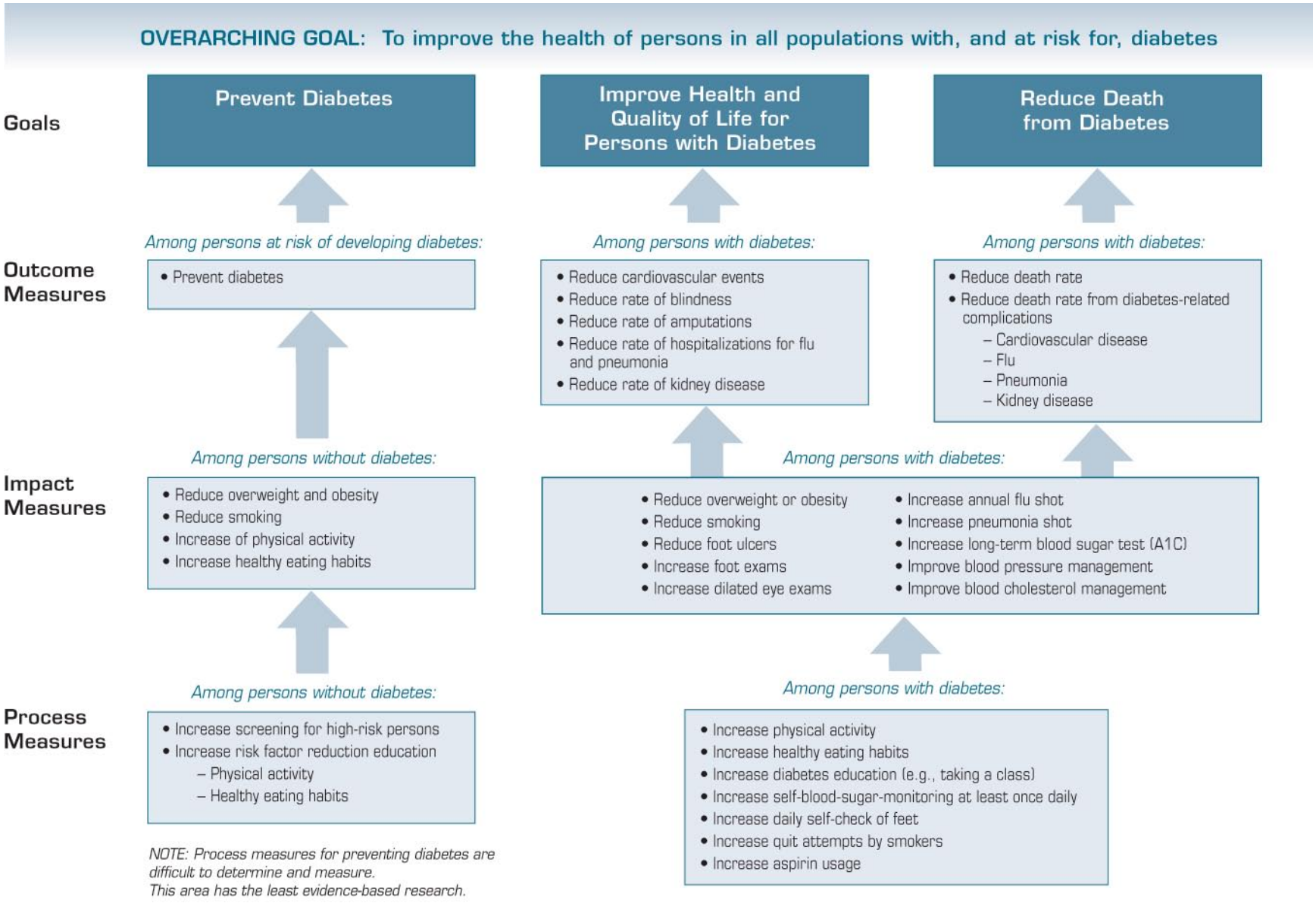
Strategic Plan Logic Model

PLAN COMPONENT	ACTIONS	STRATEGIES	GOALS
Health Communications and Public Awareness	• Convene a symposium of communications managers to discuss diabetes-related communication objectives, messages, messengers (message distribution channels), and research demonstrating their effectiveness. • Integrate message and messenger-reported experiences into a synopsis of best communication practices with special and segmented general population groups; categorize research methods and costs experience.	A repository of diabetes public communication messages concerning awareness, prevention, and control is available and maintained. It includes messengers of all types (print, broadcast, electronic, third party delivery, paid and non-paid) and data on the effectiveness and efficiency of the messages and messengers.	Model public diabetes communications are developed and disseminated to all target audiences.
	• Identify benchmarks and methodologies for measuring communications cost-effectiveness and efficacy over time, e.g., awareness, knowledge, attitude, actions. • Encourage Wisconsin health-related organizations to further develop communications message and messenger research and add case histories to an information base of cost-effective health communication research.	The diabetes care community has meaningful measures to evaluate communication impact.	
	• Work with partner organizations to promote and evaluate simple, consistent messages that providers can use with high-risk patients. • Seek external funding to measure changes in public perception and actions due to communications.	Wisconsin health providers are aware of, and involved in, public diabetes communication programs and communications research.	
Health Systems and Providers	• Collaborate with the Diabetes Advisory Group and other partners to implement the *Wisconsin Essential Diabetes Mellitus Care Guidelines,* Diabetes Prevention and Control Program resources, and other relevant and culturally appropriate resources. • Measure success, identify areas for improvement, and track outcomes to evaluate implementation of *Guidelines* and other initiatives. Share lessons learned and build on successes. • Maintain and expand partnerships for sharing new research, resources, and strategies with professionals, providers, health and community organizations, and other collaborators.	Comprehensive diabetes care is provided to residents through implementation of the current *Wisconsin Essential Diabetes Mellitus Care Guidelines,* Diabetes Prevention and Control Program resources, and other culturally appropriate and evidenced-based tools.	Wisconsin residents with diabetes are diagnosed as early as possible and, once diagnosed, experience fewer complications.
	• Foster collaborative relationships to coordinate and provide evidence-based supportive educational programs for prevention and control of diabetes, healthy lifestyles, and disease management. • Identify relevant communication channels to inform partners of current and future initiatives.	Diabetes prevention education, early screening, early detection of complications, self-management support and ongoing interdisciplinary disease management is enhanced through partnerships and increased communication with payers, providers, health and community organizations, and other relevant partners.	
	• Conduct needs assessments, design, implement, and evaluate programs for professional education, including education on aggressive risk reduction, motivation, and disease management skills. • Investigate and promote appropriate provider incentives for assuring the provision of comprehensive diabetes care and effective risk reduction practices. • Enhance the "team" concept to share expertise from other professionals. • Investigate, test, and adopt data systems and other resources that aid in disease management and tracking outcomes.	Health professionals have increased skills and resources in lifestyle modification, behavior change, and disease management, including training to provide aggressive risk reduction counseling and client empowerment.	

Strategic Plan Logic Model

PLAN COMPONENT	ACTIONS	STRATEGIES	GOALS
Population-Based Community Interventions	• Collaborate with established community health coalitions to support local needs assessments and implement innovative and culturally appropriate prevention models and environmental change policies that promote the control and prevention of diabetes. • Collaborate with businesses and employers to implement work site health programs and provide benefits that promote physical activity, healthy eating, and smoking cessation, and enhance self-management skills. • Remove barriers to health care access and participation in health and fitness-related community programs (e.g., transportation, mobility, literacy, cultural, language, etc.).	Local needs are identified and culturally appropriate interventions supporting healthy lifestyles and diabetes self-management skills are implemented in communities statewide.	Wisconsin residents are committed to healthy lifestyles and improved diabetes management.
	• Impact the health of children and youth through technical assistance and collaboration with communities, schools, and childcare providers on health-related policies, curricula, activity programming, professional education, resources, and awareness campaigns on diabetes prevention and safe diabetes management for children. • Develop and distribute talking points and tools to help schools and communities address healthy lifestyle modification, weight management, healthy eating, and physical activity for children.	Policies and interventions to prevent diabetes and ensure safe care for children with diabetes are implemented and evaluated through collaboration with communities, schools, PTA's, food service, and childcare providers.	
	• Research, develop, and promote use of a toolbox of promising behavior change strategies, culturally appropriate interventions, and evaluation protocols that promote healthy lifestyles and personal responsibility and can be adapted to meet local needs. Publish findings and share lessons learned.	Proven strategies to achieve healthier lifestyles that prevent and control diabetes are implemented in communities across the state of Wisconsin.	
	• Publish and widely distribute a listing of internet sites for accurate, culturally specific, and downloadable patient education resources and computer-based education programs. • Provide resource training for professional and community members who work in diabetes research, diabetes education, supportive social services, libraries, and public-use internet facilities.	Communities have access to reliable, accurate, and culturally relevant patient education resources and information.	

Diabetes Prevention and Control Goals and Measures



Glossary

A1C (hemoglobin A1C or HbA1C): The test for A1C indicates how well you have controlled your diabetes over the last few months. Even though you may have some very high or very low blood glucose values, A1C will give you a picture of the average amount of glucose in your blood over that time period. The result can help you and your doctor know if the measures you are taking to control your diabetes are successful.17

Acanthosis Nigricans: A skin condition characterized by darkened skin patches and common in people whose body is not responding correctly to the insulin that they make in their pancreas (insulin resistance). This skin condition is also seen in people who have pre-diabetes or type 2 diabetes.[18]

Acute: Present for a limited period of time; abrupt onset. A cold is an example of an acute illness.[18]

Behavioral Risk Factor Survey (BRFS): A national, random-digit-dial telephone survey conducted in Wisconsin by the Wisconsin Department of Health and Family Services.

Behaviors (healthy lifestyle): An individual's lifestyle choices that may affect his/her risk for diabetes or its complications. This includes things such as physical activity, eating habits, and tobacco use.

Benchmark: A point of reference or standard by which something can be measured, compared, or judged, as in "benchmarks of performance."[19]

Benchmarking: A process of measuring another organization's product or service according to specified standards in order to compare it with and improve one's own product or service. Benchmarks may be established within the same organization (internal benchmarking), outside of the organizations with another organization that produces the same product or service (external benchmarking), or with reference to a similar function or process in another industry (functional benchmarking).[20]

Best Practices: Best practices in health promotion are those sets of processes and activities that are consistent with health promotion values/goals/ethics, theories/beliefs, evidence, and understanding of the environment, and that are most likely to achieve health promotion goals in a given situation.[21]

Blood Glucose: The main sugar that the body makes from food we eat. Glucose is carried through the bloodstream to provide energy to all of the body's living cells. The cells cannot use glucose without the help of insulin.[22]

Blood Pressure: The force of the blood against the artery walls. Two levels of blood pressure are measured: the highest, or systolic, occurs when the heart pumps blood into the blood vessels, and the lowest, or diastolic, occurs when the heart rests.[22]

Body Mass Index (BMI): A formula that uses weight and height to estimate body fat. It is one factor used in determining if a person is at risk for health problems that are impacted by body stature and gauge health risks due to carrying too much weight. The BMI is only one factor in determining a person's health risk.[23]

Case Management: A process used by a doctor, nurse, or other health professional to manage your health care. Case managers make sure that you get needed services, and track your use of facilities and resources.[24]

Centers for Disease Control and Prevention, Division of Diabetes Translation: The Division is part of the National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services (DHHS). The mission of the Division of Diabetes Translation is to eliminate the preventable burden of diabetes through leadership, research, programs, and polices that translate science into practice.[25]

Glossary

(continued)

Champion: An individual in an organization who believes strongly in improvements and is willing to try them and work with others to learn them. Champions in other disciplines who work on the process are important as well.[26]

Chronic: Present over a long period of time. Diabetes is an example of a chronic disease.[18]

Coding: A mechanism for identifying and defining physicians' and hospitals' services. Coding provides universal definition and recognition of diagnoses, procedures, and level of care. Coders usually work in medical records departments and coding is a function of billing.[27]

Collaborative: A time-limited effort (usually six to 12 months) of multiple organizations that come together with faculty to learn about and to create improved processes in a specific topic area. The expectation is that the teams share expertise and data with each other, thus "everyone learns, everyone teaches."[28]

Communication Channel: The medium through which information is transmitted.[29]

Community-based Organization: A private non-profit organization which is representative of a community or significant segments of a community and which provides educational or related services to individuals in the community.[30]

Complication: Conditions that can result from poorly controlled diabetes. Complications can also be considered secondary health problems. Some examples include eye and dental disease, foot problems, and heart and kidney disease. Fortunately, most complications can be effectively delayed, prevented, or controlled.

Continuous Quality Improvement (CQI): A management approach to the continuous study and improvement of the processes of providing health care services to meet the needs of patients and other persons. CQI focuses on making an entire system's outcomes better by constantly adjusting and improving the system itself instead of searching out and eliminating persons or processes whose practices or results are outside of established norms. CQI is often considered to be synonymous with "total quality management."[20]

Cost-effectiveness: An analytic tool in which costs and effects of a program (and at least one alternative) are calculated and presented in a ration of incremental costs to incremental effects. Effects are measured in health outcomes, such as cases of a disease presented, years of life gained, or quality of adjusted life years, rather than in monetary measures.

Cultural Competency: A set of behaviors and attitudes integrated into health care practices and polices that enable providers to work effectively with people from different races, ethnic backgrounds, generations, and communities.[31]

Diabetes: The short name for the disease called diabetes mellitus. Diabetes results when the body cannot use blood glucose as energy because of having too little insulin or being unable to use insulin properly.[22] (See also: Gestational Diabetes, Pre-diabetes, Type 1 Diabetes, Type 2 Diabetes.)

Diabetes Educator: A health care professional who specializes in teaching people with diabetes how to manage their disease.[18]

Diabetes Prevention and Control Program (DPCP): Statewide program located in the Wisconsin Department of Health and Family Services, Division of Public Health. The Program is dedicated to improving the health of people at risk for, or with, diabetes.

Glossary

(continued)

Dilated Eye Exam: An eye exam in which eye drops are put in the eyes prior to the exam; the drops enlarge the pupils so that the doctor can clearly see the retina, or back of the eye.[18]

Dyslipidemia: Disorders in the lipoprotein metabolism; classified as high cholesterol, high triglycerides, combined hyperlipidemia, and low levels of high-density lipoprotein (HDL) cholesterol. All of the dyslipidemias can be primary or secondary. Both elevated levels of low-density lipoprotein (LDL) cholesterol and low levels of HDL cholesterol predispose to premature atherosclerosis.[32]

Early Detection: The process to identify a disease or health condition before there is significant damage caused to an individual's health status.

Empowerment: In relation to health information, empowerment means to give consumers the ability to take more control of their own health care and to make informed decisions.

End-Stage Renal Disease (ESRD): The point when the kidneys are so badly damaged or scarred that they fail; either renal dialysis or kidney transplantation is then required.

Essential Diabetes Mellitus Care Guidelines: Clinical recommendations developed by the Wisconsin Diabetes Prevention and Control Program and the Wisconsin Diabetes Advisory Group to help improve diabetes care across Wisconsin. It includes tools to integrate the Guidelines into clinical practice.[33]

Evaluation: A process of determining the actual status of an object (process, phenomenon, system) in relation to the desired status, or to another object (process, phenomenon, system).[20]

Gestational Diabetes: A type of diabetes that can occur in pregnant women who have not previously been known to have diabetes. Although gestational diabetes usually subsides after pregnancy, many women who have had gestational diabetes develop type 2 diabetes later in life.[22]

Guidelines: See "Essential Diabetes Mellitus Care Guidelines."

Glucose: A simple sugar; the body's primary source of energy.[18]

Health Literacy: The capacity of an individual to obtain, interpret, and understand basic health information and services and the competence to use such information and services in ways which are health-enhancing. This includes the ability to understand instructions on prescription drug bottles, appointment slips, medical education brochures, doctor's directions and consent forms, and the ability to negotiate complex health care systems. Health literacy is not simply the ability to read. Health literacy requires a complex group of reading, listening, analytical, and decision-making skills and the ability to apply these skills to health situations. Literacy varies by context and setting and is not necessarily related to years of education or general reading ability. A person who functions adequately at home or work may have marginal or inadequate literacy in a health care environment.[16]

Health Systems: Organizations that contribute to diabetes care, services, and programs.

Healthiest Wisconsin 2010 – A Partnership Plan to Improve the Health of the Public: The Wisconsin state health plan for the decade 2000-2010. It is the state health plan vision, mission, goals, objectives, and priorities for the public health system partnership.[15]

Healthy People 2010: The prevention agenda for the Nation. It is a statement of the national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats. It can be used by many different people, states, communities, professional organizations, and others to help develop programs to improve health.

Glossary

(continued)

High-density Lipoprotein (HDL): A form of cholesterol that circulates in the blood. Commonly called "good" cholesterol. High HDL lowers the risk of heart disease. An HDL of 60 mg/dl or greater is considered high and protects against heart disease. An HDL less than 40 mg/dl is considered low and increases the risk for developing heart disease.[19]

Incidence: How often a disease occurs; the number of new cases of a disease among a certain group of people over a specific period of time (e.g., one year).[18]

Implementation: The specific steps taken when attempting to reach a specific goal. The implementation phase occurs after goals have been set and a strategy has been agreed upon. Because it is a real world activity, care must be taken to observe how effective implementation is, and how well the participants (who may not have participated in the benchmarking process) are handling it. [34]

Insulin: A hormone secreted by the pancreas that regulates the metabolism of glucose.[22]

Intervention: An activity or program intended to improve outcomes.

Lipids: Fat or fat-like substances in animal (or plant) tissues that are stored in the body as an energy reserve. Lipids include cholesterol and triglycerides.[18]

Literacy: An individual's ability to read, write, and speak in English, compute, and solve problems at levels of proficiency necessary to function on the job, in the family of the individual, and in society.[35]

Medical Nutrition Therapy (MNT): MNT involves the assessment of the nutritional status of patients with a condition, illness, or injury that puts them at risk. This includes review and analysis of medical and diet history, laboratory values, and anthropometric measurements. Based on the assessment, nutrition modalities most appropriate to manage the condition or treat the illness or injury are chosen.

Media or Communication Channels: Official communication routes; for example, television, radio, print media (newspapers, journals, magazines), electronic (Internet).

Metabolic Syndrome (Syndrome X): People have the metabolic syndrome when they have several disorders of the body's metabolism at the same time, such as obesity, high blood pressure, and high cholesterol. This syndrome affects at least one out of every five overweight people. Reduction or elimination of some of the components of the syndrome are possible through positive lifestyle changes.[36]

Mortality: Related to death. Diabetes mortality is often referred to in describing the number of people that have died with diabetes during an immediate or contributing cause of their death.

National Committee for Quality Assurance (NCQA): An independent, not-for-profit organization dedicated to improving health care quality everywhere. NCQA is active in quality oversight and improvement initiatives at all levels of the health care system, from evaluating entire systems of care to recognizing individual providers that demonstrate excellence. NCQA is best known for its work in assessing and reporting the quality of the nation's managed care plans through accreditation and performance measurement programs.[37]

Glossary

(continued)

Obesity: An excessively high amount of body fat of adipose tissue in relation to lean body mass. Individuals with a body mass index of 30.0 kg/m^2 or greater are considered obese.[38]

Outcome: The result of the performance (or non-performance) of a function or process(es).

Outcome Measure: A measure of what happens or does not happen after a process, service, or activity is performed or not performed. Outcome measures quantify an organization or provider's results in providing services.[20]

Outcome Objective: Outcome (impact) objectives are higher level statements that aim to improve quality of life. The outcome objective measures benefit or change in attitude, knowledge, or health status of the target audience, such as the population, consumer, or client. The outcome objective clearly describes the "so what" (i.e., end result or accomplishment of the program).

Overweight: Increased body weight in relation to some standard of acceptable or desirable weight. Individuals with a body mass index of 25.0 kg/m^2 to 29.9 kg/m^2 are considered overweight. In most cases, persons who are obese are also considered overweight.[38]

Polycystic Ovarian Syndrome (also known as Stein-Leventhal Syndrome): An accumulation of many incompletely developed follicles in the ovaries. This condition is characterized by irregular menstural cycles, scanty or absent menses, multiple small cysts on the ovaries (polycystic ovaries), mild hirsutism (excessive hair), and infertility. Many women who have this condition also have diabetes with insulin resistance.[39]

Pre-diabetes: A condition when blood glucose levels are higher than normal but are not yet high enough to be diagnosed as type 2 diabetes.[18]

Prevalence: The number of people in a given group or population who are reported to have a specific disease at any one point in time.[18]

Prevention: Actions directed toward decreasing the probability of occurrence of diseases or accidents, or the consequences associated with such occurences.[20]

Process Measure (process indicator): Characteristics of the use of health services relative to the need and manner with which providers interact with patients in providing care relative to some standard. For example, the proportion of persons who receive beta-blockers following a myocardial infarction is a process measure related to a discrete step in the treatment of persons with heart attacks consistent with professional standards.[20]

Process Objective: Process objectives are lower level statements that address the progress made on activities during program implementation. Process objectives describe the means to achieve the stated results.

Purchaser: The buyer of health care coverage and/or services—typically employers, the government, or individuals.[40]

Qualitative: Related to, or concerning the nature or characteristics of someone or something, without regard to quantity.

Quality Improvement: The attainment, or process of attaining, a new level of performance or quality that is superior to any previous level of quality. [20]

Quantitative: Involving, or relating to, considerations of amount or size; capability of being measured.

Registry: A tool that allows health professionals to access information that is pertinent to an individual patient's care and to make queries against information for the entire patient population.[41]

Glossary

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Risk Factor: A trait that increases the chance that a person will get an illness or disease.[22]

Self-management (also known as self-care): Day-to-day activities undertaken by an individual to control and monitor their diabetes outside of the clinical setting.[18]

Self-monitoring of Blood Glucose (SMBG): A method for testing the level of blood glucose using a meter that can be done by the person with diabetes; also called home blood glucose monitoring.[22]

State Diabetes Health System: The state public health agency, including the DPCP, working in partnership with other state government agencies, private enterprises, and voluntary organizations that operate statewide to provide services essential to the health of the public with, and at risk for, diabetes.

Strategy: A series of planned and sequenced tasks to achieve a goal. Strategies must be clearly stated and observable.[42]

Surveillance: The ongoing and systematic collection, analysis, and distribution of information. Surveillance methods detect changes in trends or distribution to initiate investigative or control measurers.

Team Concept (Interdisciplinary Team): A group of professionals, paraprofessionals, and non-professionals who possess the knowledge, skill, and expertise necessary to accurately identify the comprehensive array of the individual's needs and design appropriate services and specialized programs responsive to those needs.

Third Party Reimbursement: Payment for medical care through a health plan or agency, such as an insurer.

Triglycerides: The storage form of fat in the body. High triglyceride levels may occur when diabetes is out of control.[19]

Type 1 Diabetes: A condition in which the pancreas makes so little insulin that the body cannot use blood glucose as energy. Type 1 diabetes most often occurs in people younger than age 30 and must be controlled with daily insulin injections.[22]

Type 2 Diabetes: A condition in which the body either makes too little insulin or cannot use the insulin it makes in order to turn blood glucose into energy. Type 2 diabetes can often be controlled through meal plans and physical activity. Some people with type 2 diabetes have to take diabetes pills or insulin.[22]

Wisconsin Diabetes Advisory Group: A body comprised of diabetes partners, representing health care professional, community-based, and voluntary organizations, health care delivery systems, purchasers and insurers, higher education institutions, employers, industry representatives, and people with diabetes.

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